Summary of Proposed Changes to the Delivery System Reform Incentive Payment (DSRIP) Program Funding and Mechanics Protocol (PFM) for Demonstration Years (DYs) 9-10 (October 1, 2019 - September 30, 2021)

The Special Terms and Conditions (STCs) of the 1115 Healthcare Transformation Waiver [Attachment J, Program Funding and Mechanics Protocol (PFM)] require Texas to submit the Delivery System Reform Incentive Payment (DSRIP) program requirements for demonstration years (DY) 9-10 to the Centers for Medicare and Medicaid Services (CMS) by March 31, 2019. A summary of the proposed PFM changes for DY9-10 is provided below.

Please submit any feedback on the DY9-10 PFM changes by **Thursday, January 31, 2019** through the online survey: https://www.surveymonkey.com/r/PFMDY9-10.

HHSC will review stakeholder feedback, incorporate appropriate changes, and discuss with HHSC leadership prior to formal submission to CMS. All proposed PFM changes for DY9-10 are subject to CMS approval.

Provider Valuation Reductions to Account for Pool Reductions in DY9-10

The DSRIP pool allocations for DY7-11 are as follows:

DY7	DY8	DY9	DY10	DY11
$3,100,000,000	$3,100,000,000	$2,910,000,000	$2,490,000,000	$0

The current DY7-8 valuation for the 300 participating DSRIP providers is $3,091,462,220 per demonstration year. The reduced pool amounts in DY9-10 result in a 5.9 percent reduction in DY9 and 19.5 percent reduction in DY10.

The proposed PFM changes for DY9-10 include a proportional provider valuation reduction. The reduction will affect only the 210 providers with a DY8 total valuation greater than $1 million, who account for approximately 98.5% of total DSRIP valuation in DY7-8. These providers' valuations will be reduced but not to less than $1 million.

The 90 providers with a DY8 total valuation less than or equal to $1 million will maintain their DY8 total valuation in each DY for DY9-10. This methodology promotes stability of the rural healthcare safety net during DY9-10 and affects only 1.5% of the DY8 total valuation.

The proportional reduction is based on the DY9-10 pool amounts divided by the DY8 total valuation for all Performing Providers with a DY8 valuation greater than $1 million and ensuring that providers in this group are reduced to a valuation no lower than $1 million. The percentage reduction is multiplied by the Performing Provider's DY8 valuation to determine the valuation for DY9 and DY10.

	DY9	DY10
Pool Amounts	$2,910,000,000	$2,490,000,000
Valuation for Providers ≤ $1M	- $45,074,288	- $45,074,288
Pool Amounts for Providers Reduced to $1M	-$3,000,000	-$10,000,000
Remaining Pool Amounts	**$2,861,925,712**	**$2,434,925,712**
DY8 Valuation for Providers >$1M	$3,046,387,933	$3,046,387,933
DY8 Valuation for Providers Reduced to $1M	-$3,075,699	-$11,108,124
Remaining DY8 Valuation for Providers > $1M	**÷ $3,043,312,233**	**÷ $3,035,279,808**
Proportional percentage reduction	**94.0398%**	**80.2208%**

Example: Provider ABC has a DY8 valuation of $2,150,000. Its DY9 valuation is reduced to $2,021,856 ($2,150,000 * 94.0398%), and its DY10 valuation is reduced to $1,724,747 ($2,150,000 * 80.2208%).

Refer to the *Draft Provider DY9-10 Valuations and MPTs* posted on the DSRIP Online Reporting System Bulletin Board for valuation changes to individual providers.

Provider Withdrawals: To maximize the DSRIP pool amounts for DY9-10, if a provider chooses to withdraw from DSRIP in the RHP Plan Update for DY9-10, the provider's DY9-10 valuation will be allocated proportionately among continuing providers in the RHP based on a continuing provider's DY8 valuation as a percentage of the RHP's total DY8 valuation.

Category Funding Distribution

HHSC proposes to maintain substantially the same Category funding distribution in DY9-10 as in DY8. This maintains the focus on Category C measures and minimizes changes across Categories.

	DY7	DY8	DY9	DY10
RHP Plan Update Submission	20%	NA	NA	NA
Category A - required reporting	0%	0%	0%	0%
Category B - MLIU PPP	10%	10%	10%	10%
Category C- Measure Bundles and Measures	55 or 65%	75 or 85%	75%	75%

Category D - Statewide Reporting Measure Bundle	15 or 5%	15 or 5%	15%	15%

Category A

The only change to Category A from DY7-8 to DY9-10 is that the Core Activity a provider analyzes for Costs and Savings in DY9-10 must be different from the Core Activity it analyzed in DY7-8. Analyzing additional Core Activities for the forecasted or generated savings or losses allows providers to review the merits and potential sustainability of multiple Core Activities. If a provider has only one Core Activity in DY7-10, then the provider must analyze different aspects of the Core Activity, must analyze different time periods for DY7-8 and DY9-10, or must analyze the same aspects of the Core Activity for the same time period in order to compare the costs and the forecasted savings to the costs and the generated savings.

Category B

HHSC will update the deadline for Category B plan modifications from 90 days to 30 days prior to each reporting period to align with the Category C plan modification timeframes.

HHSC will also add a requirement that providers report the breakout of Medicaid individuals and low-income or uninsured individuals in the RHP Plan Update for DY9-10 and during DY9-10 reporting. There are not separate goals for Medicaid individuals and low-income or uninsured individuals that providers are required to maintain or increase. The breakout is intended for informational purposes only that may inform planning for DY11 onward.

Category C

Minimum Point Thresholds (MPTs): To account for the reduced provider valuations, all providers' MPTs will be recalculated using the same formula as in DY7-8 except the DY10 total valuation will be used instead of the DY7 valuation. DY10 is the lower valuation in DY9-10, so it will be used in the formula instead of DY9. There is also a maximum reduction of 10 points from the DY7-8 MPT to the DY9-10 MPT. This is to ensure that the reduced MPTs do not result in providers discontinuing more than one Measure Bundle, on average.

Changes in Category C Selections: Based on the DY7-8 completion of certain non-clinical measures that will be indicated in the Measure Bundle Protocol, hospitals and physician practices may discontinue these DY7-8 measures in the RHP Plan Update for DY9-10 without impacting a bundle's point value. This is intended to allow providers to increase the valuation of clinical outcomes after the aim of process-focused measures has been accomplished.

Hospitals and physician practices may add, replace, or discontinue Measure Bundles in the RHP Plan Update for DY9-10 as long as the minimum requirements are maintained: 1) DY9-10 MPT is met with selected Measure Bundles; 2) at least half of the required measures in a selected Measure Bundle have significant volume; 3) for providers with a DY10 valuation greater than $2 million, at least one Measure Bundle is selected with a pay-for-performance (P4P) 3-point measure; and 4) for providers with an MPT of 75, at least two population-based clinical outcomes (PBCOs) are reported as P4P.

Community mental health centers (CMHCs) and local health departments (LHDs) may add, replace, or discontinue measures in the RHP Plan Update for DY9-10 as long as the minimum requirements are maintained: 1) DY9-10 MPT is met with selected measures; 2) at least two measures are selected; 3) selected measures must have significant volume; and 4) for providers with a DY10 valuation greater than $2 million, at least one 3-point measure is selected.

Category C Measure and Milestone Valuation: To standardize and simplify valuation for DY9-10, a Measure Bundle's value will be determined by the bundle's point value as a percentage of all of the provider's selected bundle's point values. For CMHCs and LHDs, all selected measures will be valued equally.

For DY9-10, HHSC will maintain the same distribution of valuation between Category C reporting and achievement milestones as it did in DY8.

	Innovative Measure (P4R) or Quality Improvement Collaborative Activity	**Pay-for-Performance (P4P) Measure**	**New DY9-10 P4P Measure**
DY7	100% Reporting Year (RY) 1 reporting milestone	25% baseline reporting milestone	NA
		25% PY1 reporting milestone	
		50% DY7 goal achievement milestone	
DY8	100% RY2 reporting milestone	25% PY2 reporting milestone	NA
		75% DY8 goal achievement milestone	
DY9	100% RY3 reporting milestone	25% PY3 reporting milestone	12.5% baseline reporting milestone
			12.5% PY3 reporting milestone

		75% DY9 goal achievement milestone	75% DY9 goal achievement milestone
DY10	100% RY4 reporting milestone	25% PY4 reporting milestone	25% PY4 reporting milestone
		75% DY10 goal achievement milestone	75% DY10 goal achievement milestone

Category C Related Strategies: HHSC will add a checklist of strategies related to each Measure Bundle for hospitals and physician practices and each measure or group of measures for CMHCs and LHDs. The checklist is completed for DY7-8 and planned for DY9 in the RHP Plan Update for DY9-10 and as a part of the Category C reporting milestone. The purpose of the added checklist is to examine common strategies across providers that may be linked to higher Category C achievement and may inform planning for DY11 onward.

Category C Goals: The Category C goals for DY9-10 for continuing measures will include additional incremental improvement over baseline performance, building on the goals established for DY7-8. The Category C goals for new measures for DY9-10 are equal to the amount of performance year improvement required for measures selected for DY7-8.

Category D

For DY9-10, HHSC will discontinue the DY7-8 private hospital participation incentive in Category D given that additional providers may choose to withdraw from DY9-10 due to the reduced pool and resulting reduced provider valuations. The DY7-8 incentive impacted all providers in an RHP if a private hospital discontinued participation.

If stakeholders have feasible ideas for encouraging continued private hospital participation, then please submit them in the online survey for HHSC consideration, question #29: https://www.surveymonkey.com/r/PFMDY9-10 and account for the limitations stated in HHSC's responses to DY7-8 PFM feedback, p. 31-33: https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-docs/Summary-PFM-Feedback-Responses.pdf.

UC-only Hospitals

HHSC will remove the learning collaborative and Category D requirements for DY9-10 for UC-only hospitals. UC-only hospitals are only required to be included in the RHP Plan Update for DY9-10 through the Anchor Template RHP Organization. UC-only hospitals may be added to an RHP Plan Update at any time through submission of an RHP Plan Update Contact Form, which is posted on the DSRIP Online Reporting System Bulletin Board.

Estimated Timeline

The following is the estimated timeline for the two DSRIP protocols (the PFM and the Measure Bundle Protocol) and the RHP Plan Updates for DY9-10:

Estimated Date	Task
March 31, 2019	PFM submission to CMS
July 31, 2019	Measure Bundle Protocol submission to CMS
September 30, 2019	CMS approval of protocols
October 1, 2019	Posting of RHP Plan Update for DY9-10 templates, *pending CMS approval of protocols*
November 30, 2019	Anchors submit RHP Plan Updates for DY9-10
January 15, 2020	HHSC completes initial review of RHP Plan Updates for DY9-10 and requests additional information
January 31, 2020	Anchors submit responses to HHSC requests for additional information
February 28, 2020	HHSC final approval or disapproval of RHP Plan Updates for DY9-10